DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF HEALTH PLAN OVERSIGHT
DIVISION OF PLAN SURVEYS

ROUTINE DENTAL SURVEY

FINAL REPORT

DENTAL BENEFIT PROVIDERS OF CALIFORNIA, INC.

ISSUED TO PLAN APRIL 4, 2003

ISSUED TO PUBLIC FILE APRIL 15, 2003

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I. INTRODUCTION

The Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), Section 1380, requires the Department of Managed Health Care (the "Department") to conduct a medical survey of each licensed health care service plan at least once every three years. The medical survey is a comprehensive evaluation of the Plan's compliance with the Knox-Keene Act. The subjects covered in the medical survey are listed in Health and Safety Code Section 1380 and in Title 28 of the California Code of Regulations, Section 1300.80.[1] A copy of this report will be sent to the Office of Enforcement.

Generally, the survey reviews the major areas of utilization management, access and availability, grievances and appeals, quality management and in the following specific categories:

- Procedures for obtaining health care services;
- Procedures for reviewing and regulating utilization of services and facilities;
- Procedures to review and control costs;
- Peer review mechanisms;
- Design, implementation and effectiveness of the internal quality of care review systems;
- Overall performance of the plan in providing health care benefits; and
- Overall performance of the plan in meeting the health needs of enrollees.

This Final Report summarizes the findings of the Routine Dental Survey of Dental Benefit Providers of California, Inc. (the "Plan"). The Plan submitted pre-survey documentary information to the Department on September 12, 2002. The on-site review was conducted at the Plan's Administrative office located in San Francisco, California on October 21-24, and November 4-5, 2002, with a telephonic exit conference on November 12, 2002. The names of the survey team members are listed in Appendix A. The names and titles of persons who were interviewed at the Plan are listed in Appendix B.

The Preliminary Report of the survey findings was sent to the Plan on January 14, 2003. All deficiencies cited in the Preliminary Report required follow-up action by the Plan. The Plan was required to submit a response to the Preliminary Report within 45 days of receipt of the Preliminary Report. The Plan submitted its response on February 28, 2003.

The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the Plan's Response and the Department's determination concerning the adequacy of the Plan's response. The Plan is required to file any modification to the Exhibits of the Plan's licensing application as a result of the Plan's corrective action plans as an Amendment with the Department. **If the Plan wishes to append its response to the Final Report, please notify the Department before April 15, 2003.**

[1] References throughout this report to "Section ____" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended [California Health and Safety Code Section 1340 *et seq*. ("the Act"). References to "Rule ____" are to the regulations promulgated pursuant to the Act [Title 28 of the California Code of Regulations, beginning at Section 1300.43. ("the Rules")].

Any member of the public wanting to read the Plan's entire response and view the Exhibits attached to it may do so by visiting the Department's office in Sacramento, California after April 7, 2003. The Department will also prepare a Summary Report of the Final Report that shall be available to the public at the same time as the Final Report.

One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost. The final report to the public will be placed on the Department's website: www.dmhc.ca.gov.

The Plan may file an addendum to its response anytime after the Final Report is issued to the public. Copies of the addendum are also available from the Department at cost. Persons wanting copies of any addenda filed by the Plan should specifically request the addenda in addition to the Plan's response.

Pursuant to Health and Safety Code Section 1380(i)(2), the Department will conduct a Follow-up Review of the Plan within 18 months of the date of the Final Report to determine whether deficiencies identified by the Department have been corrected. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The disciplinary action will be in addition to any other requirements or conditions the Department imposes on the Plan.

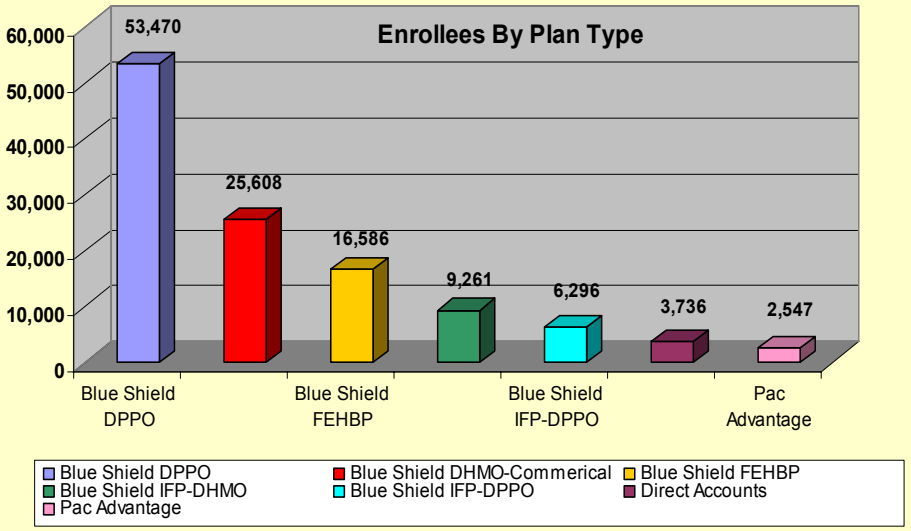
Preliminary and Final Reports are "deficiency" reports; that is, the reports focus on deficiencies found during the medical survey. Only specific activities found by the Department to be in need of improvement are included in the report. Omission from the report of other areas of the Plan's performance does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these activities or may not have obtained sufficient information to form a conclusion about the Plan's performance.

II. OVERVIEW OF PLAN ORGANIZATIONS AND HEALTH CARE DELIVERY SYSTEM

The following summary is based on information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire:

Date Plan Licensed	June 30, 1986
Type of Plan	Specialized Dental Plan
For Profit/Non-Profit Status	For Profit
Type of Managed Care Organization	Network Model HMO
Plan History	Dental Benefit Providers of California was formed in March 1985 to promote and operate programs providing high-quality prepaid dental care in the State of California. The Plan commenced operations on September 1, 1988. The company is a wholly owned subsidiary of Dental Benefit Providers, Inc. (DBP-DC). On June 2, 1999, UnitedHealth Care corporation, a Minnesota corporation, through its wholly owned subsidiary, UnitedHealth Services, Inc. (UHS), a Minnesota corporation acquired DPB, Inc.
Provider Network	As of September 2002, contracted general and specialist dentists included 951 capitated General Dentist providers and 1,325 non-capitated Specialist providers. Under the Plan's Capitated Programs, identified in the table and graph below, enrollees are required to select a general dentist to provide care for the enrollee and family. The general dentist (PCD) is expected to provide a wide range of services including anterior root canals, surgical extractions, etc. Enrollees may be referred to a participating specialist for more complicated services. The PCD is responsible for initiating and coordinating a direct referral to a specialist in accordance with Plan guidelines. Under one of the Plan's non-capitated programs the enrollee may receive services from either a participating or non-participating provider. The enrollee may select a dentist (either participating or non-participating) at the time of service and may self refer to a specialist or coordinate care through his/her general dentist.

	Plan Name	Compensation Method
Plan Types, Provider Compensation Methods, and Enrollees	**Blue Shield DPPO**-Commerical	Non-Capitated
	Blue Shield DHMO-Commerical	Capitated
	Blue Shield FEHBP (Federal Employees Health Benefits Plan)	Capitated
	Blue Shield IFP-DHMO (Individual and Family Plan)	Capitated
	Blue Shield IFP-DPPO	Non-Capitated
	Pac Advantage ***(formally known under the name of HIPPCs Plans)***[2]	Capitated
	Direct Accounts	Capitated



Service Area	As of September 2002, the Plan operated in a total of 30 Northern and Southern California counties. Refer to Appendix C for a listing of specific counties.
Plan Operation Processes	Refer to Appendix D for a summary discussion of selected Plan operation processes.

[2] Designed to allow California's small businesses of two to 50 employees can offer affordable health insurance coverage to employees and their dependents—coverage that might otherwise be available only to large organizations.

III. SUMMARY STATUS OF DEFICIENCIES

The following section contains the status of the deficiencies based on the Department's review of the Plan's Preliminary Report response. Unless otherwise noted, those deficiencies that have not been fully corrected within the 45-day requirement, will be reviewed for full correction at the time of the Follow-up Review.[3]

For any deficiency(ies) where the Department finds that the response to the Corrective Action Plan(s) is insufficient to correct the deficiency(ies), further Remedial Action may be required and will be noted by the Department below. In these cases, (which will be noted by REMEDIAL ACTION REQUIRED), the Plan will be required to submit the requested information to the Department within thirty (30) calendar days from the date of the Final Report.

Please refer to Section IV of this Final Report for specific discussion on the status of all deficiencies listed below.

QUALITY ASSURANCE PROGRAM

Deficiency 1: The Plan's Board of Directors did not demonstrate adequate oversight of the Plan's quality improvement activities. [Rule 1300.70(b)(2)(B) and (C)]
UNCORRECTED

Deficiency 2: The Plan's Quality Improvement Program does not ensure the continuous review of quality of care provided to the Plan's enrollees. [Rule 1300.70(a)(1) and (3), 1300.70(b)(2)(C)]
UNCORRECTED

Deficiency 3: The Plan has not demonstrated appropriate clinical participation in Quality Improvement Program development, monitoring of clinical services rendered, resolution of problems, and ensuring that corrective action is taken when indicated. [Section 1367.07(c), Rule 1300.70(b)(2)(D) and (E)]
UNCORRECTED

Deficiency 4: The Plan's Quality Improvement Program lacks involvement by an orthodontic provider to participate in the Plan's quality assurance activities. [Section 1367(b), Rule 1300.70(b)(1)(A)(B) and (C), 1300.70(b)(2)(E)]
UNCORRECTED

[3] Section 1380(i)(2) (2) No later than 18 months following release of the final report required by subdivision (h), the department shall conduct a follow-up review to determine and report on the status of the plan's efforts to correct deficiencies. The department's follow-up report shall identify any deficiencies reported pursuant to subdivision (h) that have not been corrected to the satisfaction of the director.

Deficiency 5: The Plan's Quality Improvement Program does not ensure that the quality of care provided is being reviewed, that problems are being identified, and effective action is taken to improve care were deficiencies are identified at orthodontic offices. [Section 1370, Rule 1300.70(a)(1) and (b)(1)(A) and (B)]
UNCORRECTED

Deficiency 6: The Plan did not demonstrate that it has a comprehensive program for the provision of preventive dental services. [Rule 1300.70(b)(2)(G)(6)]
CORRECTED

ACCESS and AVAILABILITY

Deficiency 7: The Plan did not demonstrate a documented system for monitoring and evaluating the availability of providers, including a system for addressing suspected problems. [Rule 1300.67.2(f)]
UNCORRECTED

UTILIZATION MANAGEMENT

Deficiency 8: The Plan's Utilization Management policies and procedures does not ensure that decisions based on the necessity of proposed dental services, are consistent with criteria or guidelines that are supported by sound clinical principles and processes, and developed with clinical involvement. [Section 1363.5(b) and 1367.01(f)]
UNCORRECTED

Deficiency 9: The Plan did not demonstrate adequate Utilization Management Program processes are in place to ensure that the Plan is continuously reviewing the care being provided to enrollees. [Section 1367.01(j)]
UNCORRECTED

GRIEVANCE and APPEALS

Deficiency 10: The Plan does not resolve grievances in a timely manner and does not send required letters to enrollees. [Section 1368.01(a) and Rule 1300.68(b)(7)]
UNCORRECTED

Deficiency 11: The Plan's grievance resolution letters do not provide enrollees with a clear and concise explanation of the reason for the Plan's response. [Section 1368(a)(4)]
UNCORRECTED

Deficiency 12: The Plan does not review tabulated grievance data to identify and utilize any emergent trends to formulate policy changes and procedural improvements. [Rule 1300.68(b)(1) and Rule 1300.68(b)(3)]
REMEDIAL ACTION REQUIRED

Deficiency 13: The Plan did not demonstrate a consistence mechanism for informing Plan enrollees of the grievance processes and requirements. [Section 1368.02(b)] **CORRECTED**

IV. DISCUSSION OF DEFICIENCIES, FINDINGS, AND CORRECTIVE ACTIONS

QUALITY ASSURANCE PROGRAM

Deficiency 1: The Plan's Board of Directors did not demonstrate adequate oversight of the Plan's quality assurance activities. [Rule 1300.70(b)(2)(B) and (C)]

Citation:
Rule 1300.70(b)(2)
(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components, which the QA program has identified as presenting significant or chronic quality of care issues.

Discussion of Findings: The Department's review of the Plan's Board minutes found that the board meets only once a year, usually in December. No evidence was supplied that there was any discussion of the Plan's Quality Improvement Program (QIP). For example, in the December 11, 2001 Board minutes, there is no indication that any items related to the QIP, including a discussion and approval of the following years QIP, QI Workplan, or presentation on the previous year's QI activities was discussed.

The Plan did submit a signature page reported to represent the Board's approval of the 2002 QIP. However, it could not be determined based on the information reviewed that the Board was briefed on the contents of the QIP or whether this was just fulfilling a requirement.

The Department found that although both the Quality Improvement Committee (QIC) and Clinical Affairs Committee (CAC) meet on a regularly scheduled basis, information from these

meetings, at a summary level, has not been demonstrated as being disseminated to the Board even at the Plan's current once a year Board meeting.

The Department's review of Policy QIPDES-001 states in part that, "Quarterly Reports of the Quality Improvement Committee are to be received and acted upon by the Board at its regularly scheduled meetings." However, no evidence was found that this occurred. This is in direct conflict with Rule 1300.70(c) which states in part . . . *"The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified . . ."*

Corrective Action Plan 1: The Plan shall submit a CAP which ensures that the Plan's Board of Directors are notified of significant quality issues and that documents provide evidence of the Board of Director's oversight of the Plan' QA activities is occurring on a quarterly basis.

Plan's Compliance Effort: The Plan stated in the Preliminary Report Response that they are in the process of changes to the current structure and reporting to the Board of Directors to ensure oversight of the QIP activities. The Board will meet on a quarterly basis to review the Plan's QA activities. The first meeting is scheduled for April 2003. Among the reports to be provided to Board members will include:

- QIC Indicators
- Minutes for the last three Clinical Affairs Committee meetings
- Quality Improvement Committee minutes from the previous quarter's meeting
- Current workplans

Minutes will be taken at each meeting and the Plan stated that the minutes will provide sufficient detail to reflect discussions and action items that are identified. Follow-up activities will be reported back to the Board at subsequent meetings.

This new structure, including all reporting will be in place by June 30, 2003.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

The Department reviewed the QIC Indicator sample report [referenced in the Response as Attachment A] and CAP [referenced as Attachment B]. The sample statistical report as illustrated in Attachment A appears to be designed to cover many areas including the Quality Improvement indicators such as the tracking of Quality of Care complaints and appeals and the timeliness thereof. The indicators are tracked in terms of turn-around-time (TAT) days and the percentage resolved within the "goal."

The Department is unclear what these goals are and what are the triggers that require action to be taken, when, and by whom. Some of the "TAT Days" indicators as presented on the sample report give no indication as to whether this is an average. The Plan did not supply any clarification as to how this data will be used, other than it will be reported to the Board. In addition, as denoted in the Plan's response, the Board will be given reports on the "Current workplans." Though this is a worthy effort, the Department is unclear if these are updated QI and UM workplans or other plans.

At the time the Department conducts a Follow-up Review of the Plan, the Department will make the determination whether the deficiency has been fully corrected.

Deficiency 2: The Plan's Quality Improvement Program does not ensure the continuous review of quality of care provided to the Plan's enrollees. [Rule 1300.70(a)(1) and (3), 1300.70(b)(2)(C)]

Citation(s):
Rule 1300.70(a)
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

1300.70(b)(2)
(C) . . . The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components, which the QA program has identified as presenting significant or chronic quality of care issues.

Discussion of Findings: The Department found in reviewing the minutes from the QIC and CAC that there is for the most part no discussion presented to indicate that quality of care issues are being brought to the attention of either committee for discussion. Although the Department did find some examples of client specific analysis done by Plan staff, such as with some of the Blue Shield accounts, it could not be demonstrated by either committee minutes that this analysis and recommendation are being presented. No comparative analysis or trending was found to have been presented to the QIC.

The Plan's Policy # QIPDES-001 (titled *"Quality Improvement Description"*), states in part, *"The DBPC Board of Directors structures the Quality Improvement Committee to coordinate and oversee the functions of quality improvement, utilization management, credentialing, members' rights, dental records and preventative health services throughout the network."* In addition, the policy states that the QIP is designed, *". . . to monitor and evaluate the quality and*

appropriateness of care and services provided to members through the network . . . In the Plan's Policy # QIPQIC-001 (titled *"Quality Improvement Committee"*) it is stated in part under the activities of the QIC that the committee, "*Review and evaluation of results of quality assessment indicators/performance measure/studies*," *"Review of potential quality of care and provider non-compliance issues"* and "*Establishes a network Quality Improvement (QI) Action Plan on indicator results/rates (i.e. corrective actions, performance improvement goals and follow-up studies) and on-going systemic monitoring of the indicators/important aspects of care established by DBPC."* Despite all these and other objectives of the QIP and QIC, the Department did not find evidence that these activities are actually occurring and being reviewed at the committee level.

As a result of this lack of documented evidence, the Department could not determine that the Plan is referring potential quality issues arising from enrollee grievances for quality or peer review. In two (2) grievance cases reviewed by the Department, the Plan's Dental Director directed that the cases be referred for peer review. In one (1) of these cases he indicated that the care in this case "probably fell below the standard of care." The resolution from the Plan's grievance log stated that treatment was substandard and that a "re-do" was arranged with another provider at no charge to the member. There was no indication from either file nor from committee meeting minutes that the cases had gone to peer review for appropriate follow up with the specific providers.

Corrective Action Plan 2: The Plan shall submit a corrective action plan which demonstrates the Plan's mechanism to ensure that quality of care issues are brought to the attention of the QIC and CAC and the steps to be taken to address the issues.

Plan's Compliance Effort: The Plan stated that the CAC bylaws and the QIP Program Description have been updated to clearly reflect that peer review is a function of the CAC. These documents were reviewed and approved by the QIC on February 26, 2003.

The Plan's CAC will review 10% of all quality of care cases, up to ten (10) cases and at a minimum, two (2) cases each month. Cases will be selected from quality of care grievances from all groups. The CAC will begin reviewing quality of care cases during the March 2003 meeting. The meeting minutes will reflect the Committee's decisions and will be presented to the QIC.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

At the time the Department conducts a Follow-up Review of the Plan, the Department will make the determination whether the deficiency has been fully corrected.

Deficiency 3: The Plan has not demonstrated appropriate clinical participation in Quality Improvement Program development, monitoring of clinical services rendered, resolution of problems, and ensuring that corrective action is taken when indicated. [Section 1367.07(c), Rule 1300.70(b)(2)(D) and (E)]

Citation:
Section 1367.01
(c) Every health care service plan subject to this section shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

Rule 1300.70(b)(2)
(D) Implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate.

(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

Discussion of Findings: In the interview with the Plan's Dental Director, he revealed that he only spends three (3) to four (4) hours a week at the Plan's administrative office. His responsibilities as the Plan's Dental Director are in addition to his full-time employment with Solano County where he is Chief of Dental Services. Although it was stated that he is accessible via e-mail, it was clear that the Dental Director is unable to be responsible for oversight of the QIP, with this limited time commitment. It was further found that non-clinical staff completes the development of the QIP and QI Workplan annually and that the Dental Director is used as an advisor to the process rather than actively taking part in the program's development and implementation.

Corrective Action Plan 3: The Plan shall submit a corrective action plan that demonstrates how the Plan will ensure more active involvement by the Dental Director in the development and implementation of the Plan's QIP, QI Workplan, and monitoring of clinical services provided.

Plan's Compliance Effort: The Plan stated that the timesheets provided by the Dental Director indicate that he is working 2-3 times that amount during the average workweek. Despite this clarification, the Plan acknowledges the need for its Dental Director to increase his involvement to ensure appropriate clinical participation in Quality Improvement Program development, monitoring of clinical services rendered, resolution of problems, and ensuring that correct action is taken when indicated. The Plan stated that the following items have been identified as additional responsibilities of the Dental Director.

- Submission of a detailed monthly report, which identifies action items and completed tasks. The Plan states that this report is intended to ensure that the Dental Director's involvement in the appropriate projects are met and to ensure deadlines are met.
- Participation in monthly management meetings with Credentialing Supervisor and COO to ensure activities of the QM staff as well as the development of all QA workplans include active participation from the Dental Director.
- Active involvement in the monthly Clinical Affairs Committee and quarterly Quality Improvement Committee meetings and follow-up meetings.
- Participation in Parent Company's technology committee.

The Plan states that these activities are intended to increase the Dental Director's role within the organization as well as his hours. The implementation of these tasks is underway and the Plan expects the items to be fully implemented by the end of April.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

At the time the Department conducts a Follow-up Review of the Plan, the Department will make the determination whether the deficiency has been fully corrected. Included will be a review of documented evidence of the Dental Director's involvement in all aspects of the QIP.

Deficiency 4: The Plan's Quality Improvement Program lacks involvement by an orthodontic provider to participate in the Plan's quality assurance activities. [Section 1367(b), Rule 1300.70(b)(1)(A)(B) and (C), 1300.70(b)(2)(E)]

Citation(s):
Section 1367
(b) All personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

1300.70(b)(1)
(A) . . .a level of care which meets professionally recognized standards of practice is being delivered to all enrollees

(B) . . . quality of care problems are identified and corrected for all provider entities;

(C) . . . physicians (or in the case of specialized plans, dentists, optometrists, psychologists or other appropriate licensed professionals) who provide care to the plan's enrollees are an integral part of the QA program;

1300.70(b)(2)
(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

Discussion of Findings: The Plan does not currently have any representation in the orthodontics discipline (an orthodontist by training) involved in the QIP of the Plan beyond carrying out audits of providers. As stated previously, the Plan's Dental Consultant works on average three (3) to four (4) hours per week at the Plan's administrative office. In addition to his responsibilities as the chief the Plan's dental consultant for general dentistry services, he also serves as the lead orthodontic consultant for the Plan as well. Part of his reported responsibilities as an orthodontic consultant requires rendering decisions concerning the quality review program for the Plan's orthodontic offices. However, based on the Department's review of the Dental Consultant's license and educational background he does not have the appropriate training and certification to effectively serve as the consultant for the Plan's orthodontic program.

Currently, the Department found that the only true linkage with orthodontists is through arrangement with independent auditors to conduct audits of its orthodontic providers. They do not provide input to the QIP or act as a consultant to the Plan on quality matters such as follow-up to audit findings and evaluation and resolution of orthodontic grievances.

The Department also found in reviewing the composition of the QIC and CAC that all clinical representatives within these committees involve general dentists. There was not any evidence to demonstrate that specialty providers (at a minimum in the area of orthodontics) are routinely part of either of these committees. It is unclear, based on the current composition of these committees, how quality of care issues related to specialty services are appropriately evaluated and acted upon at either committee level, particularly as it relates to orthodontics.

Corrective Action 4: The Plan shall submit evidence of involvement by an orthodontist who participates in advising the Plan on quality assurance activities for the Plan's orthodontic program, which includes a review of quality of care grievances filed by enrollees concerning the quality of orthodontic services.

Plan's Compliance Effort: The Plan stated that, at the time of the response, they were finalizing an agreement with a licensed orthodontist, to participate in our quality assurance activities as an Orthodontic Consultant. The orthodontist will be responsible for clinical review of orthodontic quality of care grievances, monitoring the orthodontic site audit program, providing input on policies and procedures related to orthodontics and providing input to the CAC and/or QIC on orthodontic issues as needed. The Plan submitted the job description for the orthodontist.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time. The involvement of the Orthodontic Consultant had not become effective at the time of the Preliminary Report Response. As a result, there was no evidence provided in the Plan's Response to demonstrate that the consultant's involvement has strengthened the quality assurance activities to date. More time is needed to fully evaluate the effectiveness of the process and oversight.

The Department's review of Policy #QIPQIC-001 [titled "Quality Improvement Committee] and Policy #QIPCAC-001 [titled "Clinical Affairs Committee Bylaws] found that the new Orthodontic Consultant is not included in either committee as a standing member of the committee. Though the Orthodontic Consultant is not listed, the Plan does include the Vice President of Sales and Marketing, though the purpose in both committees is driven by quality and appropriateness of care.

At the time the Department conducts a Follow-up Review of the Plan, the Department will make the determination whether the deficiency has been fully corrected. Included will be a review of documented evidence of the Orthodontic Consultant's clinical review of orthodontic quality of care grievances, monitoring the orthodontic site audit program, providing input on policies and procedures related to orthodontics and providing input to the CAC and/or QIC on orthodontic issues.

Required Clarification: The Department is requiring that the Plan provide clarification as to why the Orthodontic Consultant is not included as a standing member of these two committees, despite her proposed responsibilities as stated by the Plan.

The Plan shall submit the clarification within thirty (30) days of the date that the Plan receives the Final Report.

Deficiency 5: The Plan's Quality Improvement Program does not ensure that the quality of care provided is being reviewed, that problems are being identified, and effective action is taken to improve care were deficiencies are identified at orthodontic offices. [Section 1370, Rule 1300.70(a)(1) and (b)(1)(A) and (B)]

Citation(s):
Section 1370 States in part . . . Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

Rule 1300.70(a)(1)
The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are identified, and that follow up is planned where indicated.

1300.70(b)(1)
(A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;

(B) quality of care problems are identified and corrected for all provider entities;

Discussion of Findings: The Department found that one of the Plan's primary sources of information on the quality of care for orthodontics, the provider audit tool, may not accurately reflect the quality of care provided by its providers. The Department found that the current tool does not include the standard ratings of:

1. Chief complaint of the enrollee
2. Medical history
3. Medical history follow-up
4. Pertinent medical history information that could impact treatment
5. Oral examination/soft tissue evaluation
6. Treatment options presented to the patient
7. Diagnostic information
8. Evaluation of the quality of treatment records (study models, x-rays, photos, etc.)

In addition, the audit tool rating identifiers were found not to be in the normal "acceptable " or "not acceptable" format. Instead, the rating identifiers were as follows and often interpreted differently by different orthodontic auditors whose work was reviewed by the Department. The current rating system that the Plan uses include the following categories:

1. "A" = always
2. "U" = usually
3. "S" = sometimes
4. "N" = never
5. "NA" = not applicable

In reviewing a sample of the audits conducted by the Plan, the first three (3) identifiers were not always applicable to the elements being rated. For example, the element "treatment outcome" was frequently found to have been rated "A" even though it applied to a single patient and frequently there were no final treatment records to base a treatment outcome on. The rating "U" lacked sufficient specificity. It could not be determined if it implied 40% of the time, 60% of the time or some other value which was not recorded.

The issue of appropriateness in evaluating and recording was also found in the use of the category of "S" and its significance in attempting to evaluate the audit reports. For example, in one provider audits reviewed, all five (5) cases had treatment outcome ratings of "S" which was incapable of interpretation. Further, for all five (5) cases, there were no final records included for the Department's review to properly evaluate treatment outcome.

It should be noted that the Department had difficultly obtaining comparison orthodontic records for 88 patients from 12 providers which the Department had requested and which had been reported audited by the Plan. Where comparisons could be made with the Plan's audit, the Department found areas of concern. The Department also found several examples where the

Plan's audits indicated deficiencies, which were either that the Plan did not follow-up with the provider to see if the issue was corrected or the documentation was not available that the follow-up did occur as stated by the Plan.

Corrective Action 5: The Plan shall submit a corrective action plan to demonstrate the development of procedures so that deficiencies in the quality of orthodontic care (as determined by a revised audit tool) are identified when care is below professionally recognized standards. Included should be, but not limited to, a description of the on going monitoring, evaluation and verification of the accuracy of on-site quality of the Plan's orthodontic chart audits.

Plan's Compliance Effort: The Plan stated that they are in the process of revising the orthodontic audit tool to incorporate the Department's suggestions.

In addition, the Plan is developing an auditor training seminar for the third quarter of 2003. All orthodontic auditors will be required to attend the training in order to perform orthodontic audits for the Plan. The seminar will be led by the Plan's Dental Director, in conjunction with the soon to be hired Orthodontic Consultant and will include a comprehensive review of the audit tool to improve consistency across auditors.

The Plan stated that in order to further monitor, evaluate, and verify the accuracy of on-site audits the Plan will be implementing a concurrent review program. In addition, one of the responsibilities of the new Orthodontic Consultant will include monitoring the orthodontic site audit program. At least once per year, the orthodontic consultant will meet with each auditor to perform concurrent review of orthodontic charts. The Plan stated that this is designed to help to ensure consistency across auditors as well as to identify opportunities for improvement for each auditor. When appropriate, additional training will be provided to the orthodontic auditors to ensure that they more accurately assess the quality of care provided by the providers.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time. The involvement of the Orthodontic consultant had not become effective at the time of the Preliminary Report Response. As a result, there was no evidence provided in the Plan's Response to demonstrate that the consultant's involvement has strengthened the quality assurance activities to date. More time is needed to fully evaluate the effectiveness of the process and oversight.

At the time the Department conducts a Follow-up Review of the Plan, the Department will make the determination whether the deficiency has been fully corrected.

Deficiency 6: The Plan did not demonstrate that it has a comprehensive program for the provision of preventive dental services. [Rule 1300.70(b)(2)(G)(6)]

Citation:
Rule 1300.70(b)(2)(G)
(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

Discussion of Findings: The Department's review of Policy #QIPPH-001 [titled *"Preventive Health"*] which was approved on January 1, 2002, found that the Plan reports to intend to measure various indicators of preventative health using targets consistent with the nationwide "Healthy People 2010"[4] (HP 2010) program. The policy states that results "will be shared internally with DBPC clients and individual providers in an effort to educate and improve results." The measurements include access (proportion of persons aged 2 and older) who report having had a dental visit in the past 12 months, preventive services (proportion of children and adolescents) who have received a preventive health visit in the last year, topical fluoride (proportion of children and adolescents who received a topical fluoride treatment in the last year), and sealants (proportion of children and adolescents who have had at least one sealant applied to their first or second molars). Each of these measurements has defined HP 2010 benchmark figures to gage results to. The responsibility for the studies is to be coordinated between the Quality Improvement area and the Plan's Dental Director.

The Plan, however, did not supply any evidence of a timeline for these studies and no evidence was presented that the studies have been initiated. In addition, the Department's review of the 2002 QI Workplan does not provide any evidence that timelines have been established. Although the policy describes the responsible parties for this study, there is no corresponding identification in the QI Workplan as would be expected.

The Department reviewed one of the Plan's pre-survey submissions labeled "Item DRGPS-20", *Dental Benefit Providers Adult Dental Health*, which is a two (2) page flyer and Children's *Dental Health,* also two (2) pages. The Department found that these informational pieces are not dated and there is no related policy or timeline or evidence presented that these have been distributed. There is also no content related to any of the measurement items related to the Plan's Preventive Health Policy QIPPH-01 (access, preventive services, topical fluoride and sealants).

The Department did not find any evidence, based on the materials provided, that the Plan educated its enrollee about the recommended dental preventative care services and how to obtain

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4 Healthy People 2010 is a set of health objectives for the Nation to achieve over the first decade of the new century. It can be used by many different people, States, communities, professional organizations, and others to help them develop programs to improve health.

Healthy People 2010 builds on initiatives pursued over the past two decades. The 1979 Surgeon General's Report, *Healthy People*, and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* both established national health objectives and served as the basis for the development of State and community plans. Like its predecessors, Healthy People 2010 was developed through a broad consultation process, built on the best scientific knowledge and designed to measure programs over time.

them. Although stated in Policy #: QIPPH-001 that, *"all results of each study are submitted to the Clinical Affairs Committee for review and recommendations to the Quality Improvement Committee for overall effectiveness in accordance with the scope and NADP[5] criteria,"* the Department did not find any evidence to support this contention when a review was done of both the QI and CAC minutes.

Corrective Action 6: The Plan shall submit a corrective action plan that demonstrates the development and implementation of mechanisms to ensure that Plan enrollees receive appropriate preventive care services. The Plan must demonstrate that preventive care services are a more prominent element of its QIP and 2003 QI Workplan.

Plan's Compliance Effort: The Plan stated in the Preliminary Report Response that Policy QIPPH-001 [titled *"Preventive Health"*] consists of three main components:

- Measurement – measure various indicators of preventive health
- Feedback – results of studies will be shared internally with Plan clients and individual providers in an effort to educate and improve results
- Education – of both Plan dental providers and members through a combination or communication and outreach

The Plan stated that their primary focus in 2003, is implementing the following initiatives regarding preventive care services:

- Measurement: The first series of reports looking at preventive services for children and adolescents (specifically codes D1120, D1201, D1203, and D1351) will be presented at the second quarter QIC meeting.
- Feedback: The feedback component will be driven by the discussion at the Quality Improvement Committee meeting. At a minimum, it will include a newsflash article to the provider network.
- Education: Currently, the Plan will provide education materials regarding preventive services to our members via:
- The Plan's website is available to all members and providers. Articles on the website include information on brushing and flossing as well as other dental tips, tooth trivia and links to other sites. In addition, the Plan works with their clients such as Blue Shield of California and United Healthcare to provide information to members regarding preventive dental health services via their websites.
- Health Fairs: The Plan participates in Health Fairs with our clients. The Plan routinely participates with the City of San Jose Health Fair each May. Member literature provided at the health fair includes "Adult Health and Children's Dental Health" fliers. Both items have previously been provided to the Department. Additional materials are being developed for this year's health fair in May 2003.

The Plan stated that these items will be updated, as necessary, pending the results of our initial study to be completed by the end of the second quarter.

[5] National Association of Dental Plans

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that the Plan's corrective actions are adequate to correct this deficiency.

ACCESS and AVAILABILITY

Deficiency 7: The Plan did not demonstrate a documented system for monitoring and evaluating the availability of providers, including a system for addressing suspected problems. [Rule 1300.67.2(f)]

Citation:
1300.67.2
(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

Discussion of Findings: The Department's review of the Plan's Policy# QM-QIPMRR, [titled *"Members' Rights and Responsibilities"*] found that the Plan has defined the geographic access standards for both General Dentist and Specialists in the Urban, Suburban, and Rural settings. In addition, this policy also defines the standards for wait times by appointment type. The Plan also submitted several examples of completed GEO Access Studies. These studies are conducted for specific product types such as Blue Shield of California's Dental Preferred Provider Organization (DPPO) and Dental Health Maintenance Organization (DHMO).

Among the monitoring mechanisms mentioned in Policy QM-QIPMRR, it is stated that the CAC will review for trends to recommend improvements including those related to "Members/Providers with complaints/grievances relative to availability." However, the Department's review of available CAC minutes did not give any indication that an assessment of complaints and grievances related to availability of providers or appointments. A review of the QIC minutes indicates a standard agenda topic involving Accessibility based on GEO Access studies that had been completed by staff. The minutes reflect comments presumably made by staff, on the percentage of enrollees (employees in this case) with access to General Dentists in overall terms. There is an additional category that reports on "Employees without desired access." but this was not identified in the committee minutes. Both scenarios, with and without, identify "Key geographic areas" to the city level. The Department's review of the QIC minutes found that the Plan focuses on the percentage of enrollees having access and provides no indication as to any concern as to what to do to address the areas that are without reasonable access to providers. There was no indication at either the CAC or the QIC as to any corrective action plans being developed to address those areas that are without reasonable access.

In addition, the Department found that there was not any connection drawn by means of analysis between potential access issues and number of grievances received in addition to the GEO access studies. Grievances are a good gage of what the enrollees are actually viewing as potential problems. For example, a review a grievances filed for the period of September 1, 2000 to August 31, 2002 in the Plan's top two products in terms of enrollees, Blue Shield's DPPO and

DHMO, found that 32 (or 34%) and 54 (or 25%) respectively of the total grievances filed by both enrollees and providers involved issues related to access of both General and Specialist providers. Although the Department acknowledges that on a month-to-month basis, the access issues are not many, on a quarterly basis the issue become more apparent and cannot be ignored though the Geo access studies may indicate no possible problems. The Department did not find any evidence that analysis of the grievances related to access is on going.

Finally, the Department reviewed two (2) satisfaction surveys conducted, one by an outside agency dated October 25, 2000, titled "Customer Satisfaction Assessment of Blue Shield of California Dental Insurance", and the other, presumably done by Plan staff titled, "2000 Satisfaction Survey Results California General Dentists." No additional and more current studies were available for the Department's review, though the Department requested studies completed for "2000, 2001, and 2002, if available". Due to the date of these studies conducted and lack of evidence by means of committee minutes, it is unclear how this information was presented, what conclusions were drawn by the Plan, what actions were recommended to be taken, and what were the results. It was unclear whether any additional studies have been conducted on an annual basis at both the enrollee and provider level.

Corrective Action 7: The Plan is to submit a corrective action plan which demonstrates the mechanism the Plan will use to ensure on-going monitoring, analysis, and reporting of availability of providers and access to care for enrollees. Included should be, but not limited to, a description of how the information will be reported to the various committees and how often; monthly, quarterly, yearly.

Plan's Compliance Effort: The Plan stated that their Network Development (ND) Department uses information from a variety of sources to identify access deficiencies. These sources include Geo-Access reports, member inquiries, proactive provider calls, provider visits, information from site auditors, and the recredentialing process. Once the ND Department identifies an access issue, they report to implement a plan of action that will ensure that the Plan's access standards are met.

The ND Department has five (5) Network Management Specialists (NMS) who are assigned to specific geographical areas where they are responsible for maintaining and ensuring network access standards are met. The ND Department makes approximately 480 proactive provider calls and 100 provider visits each quarter. These outreach activities help the Plan monitor, respond, and take appropriate action in meeting network and access concerns. In addition, since each NMS is assigned to a specific area they become familiar with their territory and know where additional attention is needed for possible access concerns. Provider terminations are strictly analyzed for access.

The ND Department uses Geo-Access reports to pinpoint cities where we do not have enough coverage. Once ND has identified the city and the type of specialty an area is lacking, they stated that they will launch a focused spot recruitment to address the need. The spot recruitment effort involves assigning an NMS to contract or make arrangements with identified provider types (e.g. General Dentist, Endodontist, etc.) to fulfill the access requirements. The NMS is given a set time frame to either contract or make special arrangements with the provider(s) to resolve

access deficiencies in a timely fashion. As evidence, the Plan submitted "Attachment I" [titled – *"Identified through Geo-Access Dated Assigned 4/17/02 Spot Recruitment"*] as an example of a spot recruitment effort launched in April 2002 in ten (10) cities in 2002. The projected due (completion) date was to be June 30, 2002.

In situations where an NMS is unable to contract with a provider, it is often possible to make a special arrangement with a non-participating provider. The Plan stated that they have created non-participating direct referrals to specialists for some of our participating general dentists to use when the need arises. For example, the Plan has an agreement with a non-participating endodontist in the Lodi area and a non-participating pedodontist in the Red Bluff area.

Another valuable source of information about accessibility issues is member initiated inquiries. When an inquiry is created that suggests there is an access issue, the Customer Advocacy Team (CAT) will first research the member's concern to confirm that it indicates an ongoing access issue. Once it has been determined that it is an access issue, CAT will notify the ND Department so that they may resolve the issue.

The ND Department routinely responds to access related inquiries by performing a network analysis of the area, which involves listing all the active dentists within a set mile radius and then calling the dentists on the analysis to confirm availability and access. If necessary, ND would initiate a spot recruitment effort to contract additional providers or make special arrangements to meet the access requirements.

The Plan provided the Department with an example of an access analysis performed on a provider in Nevada City. This analysis lists all the participating providers within a 30-mile radius of the provider at risk. The analysis includes the number of patients that will be affected if this provider terminates and how far these patients will have to travel to be treated by a participating provider. In this particular case, there is no access issue at this time.

In order to ensure compliance with Rule 1300.67.2(f), an ND representative will present access findings to the QIC on a quarterly basis. The QIC minutes will thoroughly document the discussion including all materials presented by the ND representative. The ND Department, it was stated by the Plan, will make its next presentation at the QIC's 2nd quarter meeting.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

The Department's review of the response indicated that there are several methods used to help prevent access issues from occurring. The one concern, however, that the Department has relates back to the Department's Discussion of Findings. This concern involves the apparent lack of use of grievance data regarding access issues. The Department did not find any evidence

presented by the Plan in their Response as to the use of grievance data, or even the process by which grievance data could be used to determine if there are access issues with either General Dentist or Specialist. At the beginning of the Plan's response it is stated that the Network Development Department uses information from a variety of sources to identify access issues. The Plan goes on to state, . . . "These sources include Geo-Access reports, member inquiries, proactive provider calls, provider visits, information from site auditors, and the recredentialing process." *The Department views "Inquiries" differently than Grievances if that is what the Plan considers as potential grievances, whereas an inquiry may only be a question posed by the enrollee asking for a particular provider in the area, whereas a grievance means a written or real expression of dissatisfaction regarding the Plan and/or provider.*

In addition, the Plan did not submit the results of their efforts to correct access issues as identified in the spot recruitment effort launched in April 2002, in ten (10) cities in 2002. The projected due date was to be June 30, 2002.

At the time the Department conducts a Follow-up Review of the Plan, the Department will make the determination whether the deficiency has been fully corrected.

Required Clarification: The Department is requiring that the Plan provide clarification as to how grievances are used in evaluating access issues and how they will be reported to the various committees and what action will be taken. In addition, the Plan is to provide the Department with recap of the efforts as a result of the spot analysis, including the names of the providers contracted in those cities identified and when they became contracted providers in the network.

The Plan shall submit the clarification within thirty (30) days of the date that the Plan receives the Final Report.

UTILIZATION MANAGEMENT

Deficiency 8: The Plan's Utilization Management policies and procedures does not ensure that decisions based on the necessity of proposed dental services, are consistent with criteria or guidelines that are supported by sound clinical principles and processes, and developed with clinical involvement. [Section 1363.5(b) and 1367.01(f)]

Citation(s):
Section: 1363.5
(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(1) Be developed with involvement from actively practicing health care providers.
(2) Be consistent with sound clinical principles and processes.
(3) Be evaluated, and updated if necessary, at least annually.

1367.01
(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health

care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

Discussion of Findings: The Department's review of documents found that there was no evidence that the Plan's QIC reviewed the clinical criteria and practice guidelines to ensure that they are consistent with sound clinical principles and developed with involvement from actively practicing dental providers. In addition, there was no demonstrated evidence provided to the Department as to the criteria and guidelines being updated at least annually.

The Department found that the Plan's clinical practice guidelines do not include current professional standards of practice with regard to several standards including, but limited to, *antibiotic prophylaxis for patients at risk for bacterial endocarditis and for patients with total joint replacement following certain dental procedures* and *frequency of radiographs that are in line with current information risk of caries or periodontal disease for different age groups.* Appendix H provides some additional specific comments from the survey team general dentistry clinician on current standards of practice that were not found to be represented in the Plan's current clinical guidelines.

Corrective Action 8: The Plan shall submit a corrective action plan that demonstrates the process by which the Plan will develop UM criteria/guidelines, demonstrate that the guidelines are consistent with accepted standards of practice, developed with involvement from actively practicing providers, and demonstrated evidence that the guidelines are reviewed at least annually by the appropriate committee(s).

Plan's Compliance Effort: The Plan stated the Dental Director and Orthodontic Consultant, in conjunction with the Plan's national Dental Director are reviewing the comments provided by the Department regarding standards of care. The Plan stated that their Guidelines for Standards of Care and Claims Adjudication Policies and Procedures will be modified as needed to meet current professional standards of practice.

The Plan stated that the Dental Director, the Clinical Technology Committee and other clinicians as appropriate, are responsible for reviewing the Plan's Guidelines for Standards of Care and Claims Adjudication Policies and Procedures on at least an annual basis to ensure that they are consistent with accepted standards of practice. Recommendations for modifications will be presented to the QIC for approval. Approved changes will be made and deployed internally. The Standards of Care section of the Provider Manual will be updated at the next printing. Changes approved by the QIC will be reflected in the meeting minutes and communicated as appropriate.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

At the time the Department conducts a Follow-up Review of the Plan, the Department will make the determination whether the deficiency has been fully corrected.

Deficiency 9: The Plan did not demonstrate adequate Utilization Management Program processes are in place to ensure that the Plan is continuously reviewing the care being provided to enrollees. [Section 1367.01(j)]

Citation:
Section 1367.01
(j) Every health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

Discussion of Findings: In the Plan's Quality Improvement Program Description [Policy# QIPDES-001] under the sub-category UM it is stated in part. . . *"Utilization Management is the compilation of three separate components: network development reporting, Claims Review, and Complaint/Grievance and Appeal. Utilization data, clinical outcomes, patterns and trends are gathered and analyzed by the multi-disciplinary CAC to evaluate the continuity and appropriateness of care that the enrollees receive. Results are shared with the QIC for use in utilization and quality initiative designed to address both under-utilization and over-utilization. Actual utilization patterns will be compared in the following three areas: Clinical results or treatment choices, over/under utilization compared to network and accuracy of coding procedures. Dentist profiles will be distributed to the Quality Management Department for use in credentialing/re-credentialing. Utilization and dental management information is also incorporated into the processes for evaluating new and determining dental appropriateness for use and coverage."*

However, in reviewing the minutes from the CAC there was no evidence provided to indicate that the CAC is evaluating utilization patterns and other statistical data. Instead, the committee appears to focus on the approval and denial of providers in the Plan's network. As a result of this lack of review at this committee level, no information appears to be presented to the QIC as stated that they do. Although there appears to be an agenda item listing in the QIC minutes for utilization issues, the majority of the minutes reviewed by the Department had the comment "defer" beside the agenda topic.

The Plan submitted samples of utilization reports that have been developed for specific product lines such as the Blue Shield DHMO and Pac Advantage. However, there was no documented evidence presented how this information is used and where, at the Plan level, this information went to demonstrate appropriate oversight.

Corrective Action 9: The Plan shall submit a corrective action plan that demonstrates the development and implementation of processes for the continuous review and analysis of

utilization data, clinical outcomes, patterns and trends to ensure that the continuity and appropriateness of care is being received by Plan enrollees. Included should be, but not limited to, documented evidence that utilization data, clinical outcomes, patterns and trends being reviewed are reported to the appropriate committee(s) on a regular basis and where warranted, what corrective action are to be taken based on committee recommendations.

Plan's Compliance Effort: The Plan stated that Policy # QIPDES-001 [titled "Quality Improvement Program Description"] has been updated to reflect that the QIC is responsible for reviewing utilization data, clinical outcomes, patterns and trends.

The Plan stated that they are currently developing additional reports to be presented to the QIC as appropriate to address this deficiency. Meeting minutes will include discussion as well as corrective action recommended by the QIC.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

At the time the Department conducts a Follow-up Review of the Plan, the Department will make the determination whether the deficiency has been fully corrected.

GRIEVANCE and APPEALS

Deficiency 10: The Plan does not resolve grievances in a timely manner and does not send required letters to enrollees. [Section 1368.01(a) and Rule 1300.68(b)(7)]

Citation(s):
Section 1368.01
(a) states in part . . . "The grievance system shall require the plan to resolve grievances within 30 days."

Rule 1300.68.(b)
(7) states in part . . . "A grievance system shall provide (1) for the acknowledgement of the receipt of a complaint and notice to the complainant of who may be contacted with respect to the complaint within five (5) days, and (2) for notice and a written statement to the complainant of the disposition or pending status of the complaint within 30 days of the plan's receipt of the complaint. Where the plan is unable to distinguish between complaints and inquiries, they shall be considered complaints."

Discussion of Findings: The Department randomly selected sixty (60) grievance files from the Plan's grievance log for the period September 1, 2000 through August 31, 2002. Over a third of these cases (or 37%) took the Plan longer than thirty (30) days to resolve. Nearly half of the cases (or 43%) that the Plan had classified "quality of care," were not resolved in 30 days.

The Department reviewed thirty (30) of the sixty (60) files from the randomly selected grievance

files. In 10% (or 3 cases) of the cases reviewed by the Department, the Plan took between 50 days and 6 months to resolve the case. In the majority (or 57%) of cases, the Department was unable to determine timeliness of resolution because the files reviewed did not contain resolution letters sent to enrollees. The Plan's policy governing grievances and appeals (Policy #QM-QIPMRR [titled *"Members' Rights and Responsibilities"*] states at Section 3.a. that the Plan considers all inquiries and complaints/grievances serious in nature and thoroughly reviews them. The policy also states that the Plan will notify the enrollee within five (5) days of receipt that it has received the complaint and within thirty (30) days of receipt will send written notification about the disposition or pending status of the complaint. However, the Plan does not adhere to its policy. Rather, the Plan's practice appears to be to send a single letter to the enrollee apologizing for any inconvenience that may have been suffered.

Corrective Action 10: The Plan shall submit and implement a corrective action plan to ensure that acknowledgement and resolution letters are sent to enrollees filing a grievance or complaint within required timeframes and that all grievances and complaints are resolved within thirty (30) days.

Plan's Compliance Effort: The Plan stated that they are taking a multi-faceted approach to correct the deficiency noted by the Department.

The first phase the Plan considers short-term and is designed to have immediate impact on turn around times as well as compliant use of acknowledgement and resolution letters. This phase consists of on-going training with the staff responsible for handling grievances as well as close monitoring of turn around times and compliance with policies and procedures. The staff has received two training sessions and documentation of the process and corresponding completion dates. In addition, management staff is reported to monitor weekly reports in order to improve the time to resolve a grievance and ensure completion within 30 days.

The second phase is a long-term system solution to insure the appropriate use of letters and timeliness of resolution. The Plan, along with its parent company, is in the process of implementing a new system, referred to as "FACETS." The Plan stated that this new system includes a module for customer service and grievance letters. The Plan is currently working with the vendor to ensure all the appropriate letter templates are programmed into the system. The Plan's Customer Advocacy Team will be able to generate acknowledgement letters through the system every time a complaint is received. In addition, resolution letter templates will also be available through the system to ensure compliance and consistency. We are currently scheduled to have the system fully deployed by August 1, 2003.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

At the time the Department conducts a Follow-up Review of the Plan, the Department will make the determination whether the deficiency has been fully corrected.

Deficiency 11: The Plan's grievance resolution letters do not provide enrollees with a clear and concise explanation of the reason for the Plan's response. [Section 1368(a)(4)]

Citation(s):
Section 1368(a)(4) states in part . . . "Every plan shall do all of the following . . . Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage."

Discussion of Findings: In a minority of cases, the Plan sent a resolution letter to the enrollee rather than or in addition to the apology letter described in Deficiency 10. In at least three (3) of these cases reviewed by the Department, the resolution letter did not explain the reason for the Plan's decision. In one (1) case, the enrollee wrote to the Plan after receiving the Plan's letter stating that she did not know the disposition of her grievance while in another, the resolution appeared to be that the Plan's Dental Director offered to see the patient in his private office.

The letters of apology that the Plan sends the majority of the time do not adequately provide the enrollee with a clear and concise explanation of the reason for the Plan's response.

Corrective Action 11: The Plan shall submit and implement a corrective action plan to ensure that its grievance resolution letters provide clear and concise language and that acknowledgement and resolution letters are sent to enrollees filing a grievance or complaint within required timeframes and that all grievances and complaints are resolved within thirty (30) days.

Plan's Compliance Effort: The Plan stated that it has revised the letter templates to ensure compliance. The revised templates were included in the response. The Plan further stated that both the Customer Advocacy Team and Network Development have been trained to utilize the templates on all member correspondence. The templates provide fields for the representative to summarize the nature of the complaint/grievance. The templates also have a field to summarize the rationale for the resolution, provided that the resolution was not the outcome of Peer Review. The Plan stated that it considers all information related to Peer Review as confidential and such information is not shared with members.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time. The Plan submitted template letters to cover various different scenarios involving Grievances and Appeals. Since these are template letters, the Department was unable to see actual examples of clear and concise explanations as to the reason for the Plan's response.

At the time the Department conducts a Follow-up Review of the Plan, the Department will make the determination whether the deficiency has been fully corrected.

Additional Comment: The Department is requesting that the Plan review Attachment K2 [titled *"Appeal/Grievance Approval"*] which was submitted in the Preliminary Report Response. In this letter it is noted the following:

> *"You may appeal this denial within sixty one (61) days of receipt of this letter per Dental benefit providers of California, Inc. appeal procedures. When appealing . . . "*

Since this is understood to be an approval letter, this language does not appear to be necessary and may only confuse the enrollee. The Plan is encouraged to review the intent of this letter to ensure that they are communicating the correct and appropriate information to the enrollee.

In addition, it is assumed that the intent of Attachment I2 [titled *"Complaint Approval"*] is the resolution letter for a grievance, or in this cases a complaint. The Plan is encouraged to review the intent of this letter and consider changing the name to Grievance Resolution unless the intent is otherwise. As stated in the revised grievance regulations and corresponding Title 28 California Code of Regulations Rule 1300.68(a)(2), "Complaint is the same as a grievance."

Deficiency 12: The Plan does not review tabulated grievance data to identify and utilize any emergent trends to formulate policy changes and procedural improvements. [Rule 1300.68(b)(1) and Rule 1300.68(b)(3)]

Citation(s):
Rule 1300.68(b)(1) states in relevant part that "An officer of the plan shall be designated . . . for the review of their operations and for the utilization of any emergent patterns of grievances in the formulation of policy changes and procedural improvements in the plan's administration whether or not the plan administers its own grievance system or delegates its authority to resolve grievances to another entity."

1300.68(b)(3) states in relevant part that " . . . As to each complaint received in person or by telephone at a grievance location, a written record shall be made . . . A written record of tabulated grievances shall be reviewed periodically by the governing body of the plan. . ."

Discussion of Findings: The Department reviewed minutes from the seven (7) meetings of the Plan's QIC held between January 1, 2001 and September 30, 2002. In only two (2) of these meeting minutes was a grievance report attached. The report is not trended over time. This makes it impossible for the Plan to identify trends or patterns in the types of grievances it receives. The only set of minutes that reflected any discussion of grievances was from the first quarter 2001. These minutes simply stated that the number of inquiries was going down and did not indicate any further discussion or identification of trends or issues.

Plan staff stated during the interviews, that it tracks grievance data to identify issues and need for procedural changes by meeting weekly with Blue Shield's Dental Director to identify and resolve issues arising from member inquiries. While the Department was able to verify that this is occurring, it occurs on a case-by-case basis to solve specific problems and typically results in recommendations regarding individual provider offices. There does not appear to be any summary reporting to the Plan's senior management or governing body nor are systemic or Plan-wide issues, for example, access problems in a particular geographic area, being identified.

In addition, while Blue Shield accounts for the majority of the Plan's membership, nearly 10% of the membership is non-Blue Shield. It is not clear if any review of grievances from the non-Blue Shield membership is occurring.

The Department also reviewed minutes from the Plan's Board of Directors meetings. The Board met only once in 2001, on December 12, 2001. Minutes from this meeting stated that each director acknowledged receipt and review of the attached minutes from the various committees of the Corporation, including the QIC and CAC. Due to the inadequacy of the QIC meeting minutes, specifically the lack of aggregated grievance data and discussion, the Department determined that the Plan's Board of Directors is not reviewing grievance data.

Corrective Action 12: The Plan shall establish and implement a mechanism to review grievance data for any patterns or trends and use the data to formulate policy changes and procedural improvements in the Plan's operations. The Plan shall also revise its policies and procedures to ensure that aggregated grievance data are reviewed by the Plan's governing body.

Plan's Compliance Effort: The Plan stated that it has modified the QIC bylaws to reflect that aggregated grievance data are reviewed by the QIC. The bylaws were reviewed and approved on February 26, 2003.

Beginning with the 3rd Quarter 2002 meeting, the Plan added trended inquiry information as a regular part of the reporting package for the QIC. All inquiries initiated during the quarter are grouped into five areas: Access; Claims/ Benefit Issues; Provider Concerns; Quality of Care; and Other. For each area, the total number of inquiries as well as the number of members per inquiry is reported by quarter for the previous four quarters. This will allow the Plan to more easily identify trends and patterns in inquiries.

The Plan stated that they will continue to include all reports reviewed by the QIC in the meeting minutes. In addition, it is stated that the Plan will ensure that meeting minutes reflect the discussion and any follow-up activities as necessary.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: UNCORRECTED

The Plan's proposed Corrective Action Plan (CAP) is not adequate to remedy the deficiency as requested.

The Plan submitted a clean and redline version of Policy #: QIPQIC-001 [titled "Quality Management Committee"] as evidence of update to reflect the addition in their methods of reviewing tabulated grievance data to identify and utilize any emergent trends to formulate policy changes and procedural improvements. The Department's review of the Policy did not clearly demonstrate the change in the bylaws and more importantly the direction of the QIC in reviewing the grievance data for potential systemic trends. The only change found based on a review of the redlined versions of the policy was stated as follows in Section VI. "Activities of the QIC" where it was stated on Page 3, "Coordination of peer review and utilization review activities **including grievances, member statistics, claims accuracy, etc.**"

In addition, though the Plan mentioned in their response, "Beginning with the 3rd Quarter 2002 meeting, the Plan added trended inquiry information as a regular part of the reporting package for the QIC," *this report was not included in the Plan's response for the Department's review.*

It remains unclear how grievances are being tabulated to identify and utilize in identifying emergent trends and how this information is being used to formulate policy changes and procedural improvements. This is particularly true since in the Plan's response as stated in the previous paragraph discusses "inquiries."

REMEDIAL ACTION REQUIRED: The Plan is to re-submit its policy and procedure and any additional relevant information to fully demonstrate the Plan's mechanism to review grievance data for any patterns or trends will work. In addition, the Plan is to submit evidence as to the process by which this information will be used to formulate policy changes and procedural improvements.

The Plan shall submit the preceding, within thirty (30) days of the date that the Plan receives the Final Report.

Deficiency 13: The Plan did not demonstrate a consistence mechanism for informing Plan enrollees of the grievance process and requirements. [Section 1368.02(b)]

Citation:
Section 1368.02
(b) Every health care service plan shall publish the department's toll-free telephone number, the California Relay Service's toll-free telephone numbers for the hearing and speech impaired, the plan's telephone number, and the department's Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number, and the department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type.

Discussion of Findings: The Department's review of several of the Plan's Evidence of Coverage (EOC) booklets, (Blue Shield's "Dental HMO Plan" and "Dental Smile *Delux* Plan,") found that the EOCs contain the required Department language related to the grievance process. The Plan stated during interviews that the responsibility for the updating of the Plan's Blue Shield EOC's is the responsibility of Blue Shield as part of the terms of the contract with Blue Shield to provide dental services.

However, in the Department's review of one of the other dental plans marketed by the Plan found incorrect information being provided to enrollees. The EOC booklet for the City of San Jose contains outdated and incomplete information for the enrollees to use if they are in need of contacting the Department for assistance. The phone number was incorrectly listed and there was no corresponding number for the hearing and speech impaired along with some additional required information. The Department found that this publication, titled *"City of San Jose Membership Handbook,"* was issued to cover the year 2003.

Corrective Action 13: The Plan shall submit a corrective action plan that demonstrates how the Plan will ensure that enrollees, regardless of the plan type, will be communicated no less than annually on the various aspects of the grievance process, including the right to contact the Department. In addition, the Plan is to submit revised copy for the City of San Jose EOC that includes the required Department language. The Plan is to submit a timeline for completion of the update process and demonstrated evidence that the Plan has completed the notification process to the enrollees covered by the City of San Jose contract.

Plan's Compliance Effort: The Plan stated that a combined member handbook and EOC includes information about the grievance process, including the right to contact the Department. A supply is provided to each client for distribution to the membership on an annual basis upon group renewal. In addition, the Plan stated that it provides some clients, including PacAdvantage, with an electronic version of the member handbook/EOC upon renewal that they may post on their website.

Currently, all EOB's issued to members include information about the grievance process. This information will be available on our website in July 2003 as well.

The Plan acknowledges that the 2003 version of the City of San Jose Membership Handbook did not have the current, complete information for enrollees to contact the Department. The Plan reports that it has modified the member handbook to include the required language. After updated versions of the handbook have been printed, they will be forwarded to the client for distribution to plan members.

The Plan expects to complete the update and notification processes by March 31, 2003.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that the Plan's corrective actions are adequate to correct this deficiency.

The Plan submitted both a clean and redline version of the EOC booklet for the City of San Jose. The Department's review of the revised booklet does indicate that the Plan has updated the Department's Grievance Process information.

A P P E N D I X A

List of Surveyors

The Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Dan McCord, MBA	Staff Health Care Service Plan Analyst (DMHC Survey Lead)
Ann Vuletich, MPA	Associate Health Care Service Plan Analyst
Howard Pollick, DDS	Consultant (General Dentistry)
Julian Singer, DDS	Consultant (Orthodontics)

A P P E N D I X B

List of Staff Interviewed

The following are the names and titles of key Plan officers and staff who were interviewed during the on-site survey at the Plan's administrative offices on October 22 and November 4, 2002.

DENTAL BENEFIT PROVIDERS OF CALIFORNIA. INC.	
Jill Schultz Evans	General Manager Western Region, Chief Operating Officer
Franklin Woo, DDS	Dental Director
Katayoun (Katy) Karimi, DDS	Dental Consultant (Utilization Management), Plan Auditor
Lili Schmelzinger, MPA	Assistant Director Customer Advocacy Team
Jacob Fisher	Supervisor, Clinical Credentialing
Kenneth Gaydon	Regional Plan Manager

A P P E N D I X C

Service Area By Counties

County	County	County
Alameda	Napa	Santa Barbara
Butte	Orange	Santa Clara
Contra Costa	Placer	Santa Cruz
El Dorado	Riverside	Solano
Fresno	Sacramento	Sonoma
Kern	San Bernardino	Stanislaus
Los Angeles	San Diego	Sutter
Marin	San Francisco	Ventura
Merced	San Joaquin	Yolo
Monterey	San Mateo	Yuba

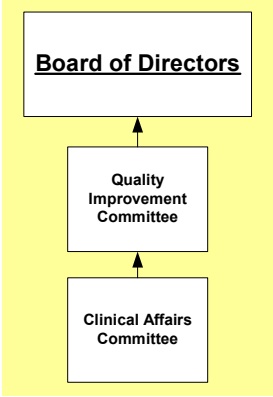
A P P E N D I X D

Summary Overview of Selected Plan Operation Processes

QUALITY MANAGEMENT

The Plan's Quality Improvement Program (QIP) is defined in Policy# QIPDES-001 (titled *"Quality Improvement Program Description"*). The Plan's Dental Director is responsible for the oversight and evaluation of clinical quality of health care services provided to members and provides clinical input to the QIP. The Chief Operating Officer (COO) oversees quality improvement activities and provides direction to the QIP. The policy outlines the COOs specific responsibilities.

Organizationally, the Plan's Board has overall responsibility for the oversight of the effectiveness of operational components of the QIP to the Quality Improvement Committee (QIC). The Board receives quarterly reports at regular meetings and reviews and approves the QIP annually.



The QIC has the responsibility for coordinating and overseeing the functions of quality improvement, UM, credentialing, members' rights, dental records and preventive health services throughout the network. The QIC oversees the effectiveness of the Plan's quality improvement activities and dental health management programs. The Committee is comprised of:

- ❑ Dental Director*
- ❑ Account Executive
- ❑ Client (as specified)*
- ❑ Plan Associate General Counsel
- ❑ Dental Consultant #1*
- ❑ Dental Consultant #2
- ❑ QA Coordinator*
- ❑ Blue Shield Dental Director*

* *Indicates voting members.*

The Plan stated that as of date of submitting the pre-survey materials, 66% of their network was credentialed in accordance with their policies and timeframes. Many were currently in credentialing or re-credentialing as per the Plan's 2002 QIP Workplan. The Plan's goal is to be at 80% by the end of the year.

QUALITY MANAGEMENT *(CONTINUED)*	The Clinical Affairs Committee (CAC) provides representative dentist and network input on clinical issues to the Plan's Dental Director. The committee acts as a designated peer review committee. The CAC provides input to the QIC on network standards such as access, dental record documentation, preventive service, credentialing/re-credentialing, member complaints, and utilization. Also the CAC communicates the Plan's Best Practices and quality improvement reports to participating providers. The COO selects the members of the QIC. The Network Quality Improvement area is composed of the Dental Director, at least 2 other dentists and 1 administrative representative. The chairperson appointed by the COO. The QIC receives regular reports from Network Development, QM, Member Services, Claims, and others on satisfaction survey results, customer complaints, grievances, telephone access, and disenrollment results. Components of the QIP include: ❑ Routine Monitoring and Evaluation ❑ Identification of Clinical/High Risk/Priority Issues ❑ Annual Evaluation of QI and Work Plan ❑ UM (Claims Review) ❑ Credentialing and Re-credentialing ❑ Members' Rights and Responsibilities ❑ Dental Records ❑ Preventive Health Services

ACCESS AND AVAILABILITY	The Plan's Access and Availability standards are defined in Policy# QM-QIPMRR (titled *"Member's Rights and Responsibilities"*). The Plan has established measurable Access and Availability Standards which are tracked, trended and reported in accordance with oversight regulations to meet the following criteria: ❑ Number of sites accepting new members for primary care in each geographic location. ❑ Ratio of member-to-primary care dentist availability in each area with an acceptable driving time. ❑ Rates of members reporting no difficulty in finding primary dentists. ❑ Percentage of open practices within each geographic area. The Plan has thresholds for their geographic access as being "For 90% of members in area" and the corresponding mileage access standards. For example for General Dentist (GD) in an urban area the ratio is 1 GD = 5 miles; Suburban 1 GD = 10 miles; Rural 1 GD = 20 miles. Also included is the access standards for specialists including Ortho which is Urban and Suburban 1 Ortho = 20 miles, Rural 1 Ortho = 50 miles. The policy also defines appointment wait times.
UTILIZATION MANAGEMENT	The Plan's Utilization Management (UM) Program is largely managed through retrospective review at both the group and provider level. By integrating data from a variety of sources including: Individual; Client Report Packages, DBPC claims data, TRACER (Treatment, Review, Auditing, Comprehensive Evaluation and Reporting System), DBPC's utilization statistical review package, and individual audit reporting, the Plan can evaluate group and individual; provider practice patterns and identify those patterns that deviate from the norm. The Plan stated that by identifying and correcting negative provider practice patterns, the Plan can not only reduce the overall impact of such behavior on the cost of care, but also improve the quality of care delivered. In the Plan's QIP Description under the UM subcategory it is stated that UM is the compilation of three separate components: Network Development Reporting, Claims Review, and Complaint/Grievance and Appeal. Utilization data, clinical outcomes, patterns and trends are gathered and analyzed by the multi-disciplinary CAC to evaluate the continuity and appropriateness of care that the enrollees receive. Results are shared with the QIC for use in utilization and quality initiative designed to address both under-utilization

UTILIZATION MANAGEMENT *(CONTINUED)*	and over-utilization. Actual utilization patterns will be compared in the following three areas: Clinical results or treatment choices, over/under utilization compared to network and accuracy of coding procedures. Dentist profiles will be distributed to the Quality Management Department for use in credentialing/re-credentialing. Utilization and dental management information is also incorporated into the processes for evaluating new and determining dental appropriateness for use and coverage. The Utilization Management area falls under the responsibility of the Chief Dental Director (who is listed as "Managing UM Program") and Lead Dental Consultant (who is listed as the "Dentist Responsible for UM."). Preauthorization of procedures for clinician (medical) necessity is not required except for orthodontics.
GRIEVANCE AND APPEALS	The Plan submitted Policy# QM-QIPMRR (titled *"Member's Rights and Responsibilities"*). In this policy the Plan includes a section titled, "Inquiry, Adverse Decisions, Complaints/Grievance and Appeals." The Grievance process falls under the responsibility of the Chief Operating Officer. Initial calls coming into the Plan are triaged by the Plan's parent company call center located in San Antonio, Texas. Those calls that are not determined to be related to general inquiries are auto-routed to the Customer Advocacy Team (CAT) located in the Plan's San Francisco administrative office for further processing. The following is a summary of the Grievance and Appeals processes. All inquiries, complaint/grievance and appeal telephone calls or mail inquires are received and processed into the Inquiry Tracking System by a Customer Services representative. The inquiry system routes the concern to the designated member services, CAT or Network Development (ND) representative. The Quality Management department tracks, trends and reports to committees all inquires, complaint/grievances and appeals.

GRIEVANCE AND APPEALS ***(CONTINUED)***	The following are some of the standards for inquiries and complaints/grievances received by the Plan. They include: ❑ Within 5 days of receipt of a complaint, notice will be sent to the complainant acknowledging receipt of the complaint and indicating who may be contacted with respect to the complaint. ❑ Within 30 days of receipt of complaint notice sent….or pending disposition, including instruction on contacting the Department. ❑ A weekly inquiry aging report is generated and compiled, indicating all inquiries, complaints/grievances that are unresolved in the appropriate timeframe for the type of complaint/grievance (i.e. urgent, non-urgent). Calculated timeframes of 24-48 hrs, 7, 12, and 30 days respectively are reviewed and appropriate action taken." For the Blue Shield accounts, 2nd level appeals are routed to Blue Shield for a decision. All 1st level appeals are handled by the Plan.

A P P E N D I X E

List of Acronyms

Acronyms	Definition
CAC	Clinical Affairs Committee
CAT	Customer Advocacy Team
COO	Chief Operating Officer
DPPO	Dental Preferred Provider Organization
DHMO	Dental Health Maintenance Organization
EOC	Evidence of Coverage
FEHBP	Federal Employees Health Benefits Plan
HP	Health People
IFP	Individual and Family Plan
NADP	National Association of Dental Plans
QIC	Quality Improvement Committee
QIP	Quality Improvement Program
QM	Quality Management
UM	Utilization Management

A P P E N D I X F

Grievance Analysis

Information will be held confidential pursuant to Section 1380(d).

Available to Plan upon request.

A P P E N D I X G

Orthodontic Provider Audit Findings

Information will be held confidential pursuant to Section 1380(d).

Available to Plan upon request.

A P P E N D I X H

Plan Clinical Guidelines Review

Below are some specific comments from the survey team general dentistry clinician on current standards of practice that were not found to be represented in the Plan's current clinical guidelines. Where applicable references to available supporting clinical documentation is provided for the Plan's ready reference.

1. The Plan does not provide sample consent forms for providers even though the Plan audits for the existence of informed consent. This is particularly important when treatment procedures call for deviations from the usual procedures.

2. The Plan does not provide clinical practice guidelines on the frequency of radiographs that are in line with current information risk of caries or periodontal disease for different age groups. Refer to KODAK Publication N-80A *Guidelines for Prescribing Dental Radiographs* or THE CALIFORNIA RADIATION CONTROL REGULATIONS PERTAINING TO DENTAL PRACTICE California Dental Association June 1996. SECTION XI - GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS accessed at http://www.cda.org/member/policy/osha/xrayosha.html

3. The Plan's clinical practice guidelines and audit instruments do not include health history questions for specific conditions for which patients should be protected by prophylactic antibiotics for certain invasive procedures.

4. The Plan's clinical practice guidelines do not include current professional standards of practice with regard to antibiotic prophylaxis for patients at risk for bacterial endocarditis and for patients with total joint replacement, following certain dental procedures. (Standard of Care: Prevention of Bacterial Endocarditis. Recommendations by the American Heart Association. JAMA. 1997;277:1794-1801. Circulation. 1997;96:358-366, and the American Dental Association/American Academy of Orthopedic Surgeons. Advisory statement: antibiotic prophylaxis for dental patients with total joint replacements. JADA 1997;128:1004-8.

5. The Plan's clinical practice guidelines do not reflect current professional standards of practice with regard to supplementary fluoride lozenges that should be prescribed for children, in the communities with sub-optimal fluoride concentrations in drinking water. (Standard of Care: Fluoride Supplement Dosage Schedule – 1994. Approved by the American Dental Association, American Academy of Pediatrics and American Academy of Pediatric Dentistry.)

A P P E N D I X I

Provider/Orthodontic Cases

Information will be held confidential pursuant to Section 1380(d).

Available to Plan upon request.